STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155667	A. BUILDING 00 B. WING	06/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CHRISTIAN RETIREMENT VILLAGE	221 W DIVISION ST DEMOTTE, IN46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 1, 2, 3 and 7, 2011 Facility number: 010823 Provider number: 155667 AIM number: 200236630 Survey team:: Marcia Mital, RN, TC Regina Sanders, RN Census bed type: SNF: 14 SNF/NF: 34 Total: 48 Census Payor type: Medicare: 10 Medicaid: 28 Other: 10 Total: 48 Sample: 12 Supplemental Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/9/11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to thoroughly investigate	F0225	Submission of this plan of correction and credible allegation of compliance does not constitute	07/07/2011

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	and report to the Indiana State Department of Health in a timely manner, an allegation of abuse, related to an allegation of rough treatment by CNA #2 for 1 of 12 residents reviewed for abuse in a sample of 12. (Resident #37) Findings include: A facility policy, titled, "Abuse/Unusual Occurrences", dated 09/24/09, received from the Administrator as current, indicated, "...In the event the resident or another individual makes an allegation, the licensed nurse shall initiate...B. Report immediately to the Administrator and the Director of Nursing...5. The Administrator/Designee shall be responsible for initiating the investigations...All reportable unusual occurrences, including reports of suspected or known abuse shall be reported within 24 hours to the Indiana State Department of health (sic)..." Review of a facility,"Fax/Incident Report", Dated 09/14/10 at 1:35 p.m.,.indicated the initial report with the five day follow up report was sent to the Indiana State Department of Health (ISDH) and Adult Protective Services (APS). The report indicated, "...Res (resident) (resident #37) voiced concerns about how CNA renders care to him. He		an admission of the certified and licensed provider, Oak Grove Christian Retirement Village, that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care of services at this health care facility. Oak Grove Christian Retirement Village, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashon.F2251. No residents were adversely affected by the alleged deficiency. The allegation of abuse for resident #37 was reported to ISDH on 9/14/10. The allegation was thoroughly investigated at the time of the allegation via conversation with resident #37. The investigation was completed and reported to the ISDH within 5 days of the initial report.2. All residents have the potential to be affected by the alleged deficient practice. DON/Designee will review the 24 hour report sheets for the past 6 months to identify any potential areas that warrant further investigation.3. The Abuse/Unusual Occurrence Policy was reviewed. All staff will be inserviced on the policy with emphasis on reporting obligations. DON/Designee will interview 5 residents weekly to identify any issues that warrant further investigation X 30 days, then 5 monthly X 60 days.	

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	stated that CNA is rough c/ (with) him & 'too fast'. He said that CNA causes him pain when he renders care..." The report indicated it was reported to the Director of Nursing on 09/13/10. The investigation of the allegation which was received form the Director of Nursing (DoN) on 6/2/11 at 10:30 a.m., indicated the allegation was made by the resident's daughter on 09/09/10. The investigation of the allegation, received from the Director of Nursing indicated: "On Friday, Sept. 10, 2010 it was reported to me that resident (resident name) (resident #37) daughter had reported to nurse (Nurse's name) (LPN #1) that (resident name) had concerns regarding the care that he was receiving from (CNA name) (CNA #2). She said that (CNA name) was rough with (resident name) and that (resident name) did not like the way that (CNA name) handled him...I told (resident name) that I had heard that he had some concerns with the way (CNA name) treats him. He nodded his head yes. I asked him to explain to me what the concerns were. He said that he feels like (CNA name) is a 'big guy and that he does things quickly and abruptly at times.' He said that he sometimes stretches his legs out when he puts his pants on and that his		DON/Designee will review the 24 hour report sheets at least 5 times weekly to identify areas of concern that may warrant further investigation. This audit will be ongoing. DON was given 1:1 reinstruction by the Administrator regarding reporting/investigating responsibilities/obligations.4. DON/Designee will summarize the results of the audits and present the data to the Quality Assurance committee monthly to identify any trends/patterns that warrant further corrective actions. The audits will continue aftger the initial time frame until the QA committee feels that at least a 95% compliance threshold has been met.5. Date of compliance: July 7, 2011	

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	legs hurt sometimes afterwards. I asked him if he thought that (CNA name) was being abusive to him...he said 'no'. I attempted to call (CNA name) and was unsuccessful so I left him a note with (resident name) concerns and told him to be a little more careful when he is rendering care to (resident name)..." "...Monday, September 13, 2010. (LPN name) (LPN #5) called at about 7 p.m. and said that (resident name) daughter reported to her that (resident name) had reported that (CNA name) was 'mean' to him when he rendered care. I told (LPN name) to assure the daughter that I had spoken to (resident name) and that I felt like the issue was resolved...(CNA name) (midnight coworker...) 09/15/10 3:30 p.m....said she was aware of it and was present when (resident name) daughter talked with (nurse's name) on Thursday, September 9, 2010...(resident name) complained to her...can be rough at times..." "...Tuesday, September 14, 2010...Soc (Social) Service Director to talk with (resident name)...He told her that he does have a problem with the way (CNA name) renders care to him. That he is rough and hurts him. After (Social Service Director name) conversation with (resident name), I decided to further investigate and put			

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	(CNA name) on suspension pending outcome of investigation..." This was five days after the allegation was first voiced by the Resident's daughter on 09/09/10. During an interview on 06/02/11 at 11 a.m., the DoN indicated she had found out about the allegation on 09/10/10. She indicated the ISDH had not been notified because she did not feel it was an issue after she talked to the resident on 09/10/10. During an interview on 06/02/11 at 11:20 a.m., LPN #1 indicated the resident had told her the CNA was rough with him with turns. She indicted the Resident's daughter had reported the rough treatment to her on 09/09/10. She indicated she left a note for the DoN and wasn't sure if she should have called someone. During an interview on 06/02/11 at 4 p.m., the Administrator indicated he now understood the allegation should have been reported immediately. Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's diagnosis, included, but was not limited to, dementia. A quarterly/14 day Minimum Data Set (MDS) assessment, dated 07/14/10,			

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	indicated the resident had short term memory problems. A, "Mental Status Examination", dated 04/20/10, indicated a score of 4 incorrect responses (score of 3-5 errors indicated mild intellectual impairment). The Social Services Notes, dated 09/14/10 at 1 p.m., indicated, "...res. concerns about a staff member. Res alert...He stated on several occasions...staff member is too fast and too rough...staff member just pulls them out causing pain all over (legs, back, groin). That particular night he said he cried from 11 p (p.m.) until 6 a (a.m.) r/t (related to) discomfort and pain...he didn't want to cause him (staff member) any harm because I don't want him to hurt me when no one is around..." During an interview on 06/02/11 at 11:30 a.m., Resident #37 stated, "Staff handling sometimes is a concern" He indicated it had been awhile since he has been treated roughly. 3.1-28(d)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow the facility's policy for investigating and reporting allegations of abuse to the facility Administrator, and to the Indiana State Department of Health related to an allegation of rough treatment by CNA #2. The facility also failed to follow the facility's policy for protection of the resident related to a CNA continued to work at the facility after an allegation of rough treatment was reported for 1 of 12 residents reviewed for abuse in a sample of 12. (Resident #37 and CNA #2) Findings include: A facility policy, titled, "Abuse/Unusual Occurrences", dated 09/24/09, received from the Administrator as current, indicated, "...In the event the resident or another individual makes an allegation, the licensed nurse shall initiate...B. Report immediately to the Administrator and the Director of Nursing...2...interventions will be initiated by a licensed nurse to protect the resident from further abuse...5. The Administrator/Designee shall be	F0226	F226:1. No residents were adversly affected by the alleged deficiency. The allegation of abuse for resident #37 was reported to the ISDH on 9/14/10. The allegation was thoroughly investigated at the time of the allegation via conversation with resident #37. The investigation was completed and reported to the ISDH within 5 days of the initial report. The Administrator was notified of the initial allegation on 9/10/10.2. All residents have the potential to be affected by the alleged deficiency.3. The abuse/Unusual Occurrence policy was reviewed. All staff will be inserviced on the policy with emphasis on reporting obligations. Administrator will review all allegations of abuse to ensure that proper/timely notification and reporting was completed.4. The DON/Designee will summarize results of the audits and present data to the Quality Assurance Committee monthly to identify additional trends/patterns warranting further corrective actions. The audits will continue past the initial time frame until the QA Committee feels that at least a 95% compliance threshold has been met.5. Date of Compliance: July	07/07/2011

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	responsible for initiating the investigations, including removing the staff member from the facility...in order to assure the resident is protected from any further alleged abusive acts while the incident is being investigated. Measures shall include,, but not be limited to...suspension of staff member allegedly involved...All reportable unusual occurrences, including reports of suspected or known abuse shall be reported within 24 hours to the Indiana State Department of health (sic)...The administrator (sic) shall immediately identify and investigate all reportable occurrences, including but not limited to incidents of suspected resident abuse, neglect, mistreatment..whether by staff or others..." Review of a facility,"Fax/Incident Report", Dated 09/14/10 at 1:35 p.m., indicated the initial report with the five day follow up report was sent to the Indiana State Department of Health (ISDH) and Adult Protective Services (APS). The report indicated, "...Res (resident) (resident #37) voiced concerns about how CNA (CNA #2) renders care to him. He stated that CNA is rough c/ (with) him & 'too fast'. He said that CNA causes him pain when he renders care..." The report indicated it was reported to the Director of Nursing on 09/13/10. The		7, 2011	

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	investigation of the allegation which was received form the Director of Nursing (DoN) on 6/2/11 at 10:30 a.m., indicated the allegation was made by the resident's daughter on 09/09/10. The investigation of the allegation, received from the Director of Nursing (DoN) indicated: "On Friday, Sept. 10, 2010 it was reported to me that resident (resident name) (resident #37) daughter had reported to nurse (Nurse's name) (LPN #1) that (resident name) had concerns regarding the care that he was receiving from (CNA name) (CNA #2). She said that (CNA name) was rough with (resident name) and that (resident name) did not like the way that (CNA name) handled him...I told (resident name) that I had heard that he had some concerns with the way (CNA name) treats him. He nodded his head yes. I asked him to explain to me what the concerns were. He said that he feels like (CNA name) is a 'big guy and that he does things quickly and abruptly at times.' He said that he sometimes stretches his legs out when he puts his pants on and that his legs hurt sometimes afterwards. I asked him if he thought that (CNA name) was being abusive to him...he said 'no'. I attempted to call (CNA name) and was unsuccessful so I left him a note with			

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	(resident name) concerns and told him to be a little more careful when he is rendering care to (resident name)..." "...Monday, September 13, 2010. (LPN name) (LPN #5) called at about 7 p.m. and said that (resident name) daughter reported to her that (resident name) had reported that (CNA name) was 'mean' to him when he rendered care. I told (LPN name) to assure the daughter that I had spoken to (resident name) and that I felt like the issue was resolved...(CNA name) (midnight coworker...) 09/15/10 3:30 p.m....said she was aware of it and was present when (resident name) daughter talked with (nurse's name) on Thursday, September 9, 2010...(resident name) complained to her...can be rough at times..." "...Tuesday, September 14, 2010...Soc (Social) Service Director to talk with (resident name)...He told her that he does have a problem with the way (CNA name) renders care to him. That he is rough and hurts him. After (Social Service Director name) conversation with (resident name), I decided to further investigate and put (CNA name) on suspension pending outcome of investigation..." This was five days after the allegation was first voiced by the Resident's daughter on 09/09/10.			

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	A time detail form, dated 09/01/10 through 09/30/10, indicated CNA #2 continued to work in the facility on 09/10/10 through 09/13/10 on the night shift. During an interview on 06/02/11 at 11 a.m., the DoN indicated she had found out about the allegation on 09/10/10. She indicated the ISDH had not been notified because she did not feel it was an issue after she talked to the resident on 09/10/10. She indicated CNA #2 was suspended on 09/14/10. During an interview on 06/02/11 at 11:20 a.m., LPN #1 indicated the resident had told her the CNA was rough with him with turns. She indicted the Resident's daughter had reported the rough treatment to her on 09/09/10. She indicated she left a note for the DoN and wasn't sure if she should have called someone. During an interview on 06/02/11 at 4 p.m., the Administrator indicated he now understood the allegation should have been reported immediately. Resident #37's record was reviewed on 06/02/11 at 11:40 a.m. The resident's diagnosis, included, but was not limited to, dementia.			

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	A quarterly/14 day Minimum Data Set (MDS) assessment, dated 07/14/10, indicated the resident had short term memory problems. A, "Mental Status Examination", dated 04/20/10, indicated a score of 4 incorrect responses (score of 3-5 errors indicated mild intellectual impairment). The Social Services Notes, dated 09/14/10 at 1 p.m., indicated, "...res. concerns about a staff member. Res alert...He stated on several occasions...staff member is too fast and too rough...staff member just pulls them out causing pain all over (legs, back, groin). That particular night he said he cried from 11 p (p.m.) until 6 a (a.m.) r/t (related to) discomfort and pain...he didn't want to cause him (staff member) any harm because I don't want him to hurt me when no one is around..." During an interview on 06/02/11 at 11:30 a.m., Resident #37 stated, "Staff handling sometimes is a concern" He indicated it had been awhile since he has been treated roughly. 3.1-38(a)			

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F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to ensure professional standards were followed related to signing a MAR (Medication Administration Record) prior to administering the medication for 1 resident in a sample of 12. (Resident #1 and LPN #3) Findings Include: 1 Resident #1's record was reviewed on 6/2/11 at 2:45 p.m. Resident #1's diagnoses included but were not limited to, congestive heart failure, asthma, and. hypertension. A physician order, dated 5/31/11, indicated "proventil (respiratory medication)...via nebulizer QID (four times a day)..." A MAR, dated 6/11, indicated the proventil nebulizer treatment was to be administered at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. The MAR indicated the nebulizer treatment had been initialed as administered on 6/2/11 at 4 p.m. when reviewed on 6/2/11 at 2:52 p.m. During an interview on 6/2/11 at 3:10 p.m., LPN #3, indicated she had signed the MAR for the	F0281	F281:1. No residents were adversely affected by the alleged deficiency. Resident #1 received prescribed medication within scheduled administration parameters.2. All residents have the potential to be affected by the alleged deficiency.3. LPN #3 was counseled for not following professional standards of practice regarding medication administration documentation. Medication administration policy was reviewed. All licensed nurses will be inserviced on policy with emphasis on documentation. DON/Designee will perform medication pass observations on different nurses and different shifts at least 5 X weekly X 30 days and then 2 X weekly X 60 days and then weekly X 90 days. Those nurses noted to be noncompliant with medication pass policy regarding documentation will be subject to 1:1 reinstruction and further disciplinary actions as deemed appropriate.4. The DON/Designee will summarize results of medication pass audits and present data to the Quality Assurance Committee monthly to identify additional trends/paterns warranting further corrective	07/07/2011

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	nebulizer treatment, but had not administered the treatment yet. She indicated she was just getting ready to give the Resident her breathing treatment. She indicated she had to get the medication out of the EDK (Emergency Drug Kit). The "Geriatric Medication Handbook", Eighth Edition, pages 170-172, indicated "Steps of Medication Administration...Two methods are used for charting of medications, and each facility should adopt one of these methods ...The most common method is to chart medication immediately AFTER medication administration...A second method is called 'charting by exception.' In this method , the nurse initials the MAR as each medication is opened and placed into the medication cup..." 3.1-35(g)(1)		actions. The audits will continue past the initial time frame until the QA Committee feels that at least a 95% compliance threshold has been met.5. Date of Compliance: July 7, 2011	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed related to laboratory tests for 1 of 12 residents reviewed for laboratory tests in a sample of 12. (Resident #1) Findings include: Resident #1's record was reviewed on	F0282	F282:1. Resident #1 had labs completed on 6/6/11 per physician order. MD is aware that labs (BMP and PT/INR) were not completed on 6/2/11. A clarification order was received to do the labs on 6/6/11 and then again clarified to do the PT/INR on 6/3/11.2. All residents that have physician orders for labs have the potential to be affected by the alleged deficient practice. Physician orders will be audited	07/07/2011

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	6/2/11 at 2:45 p.m. Resident #1's diagnoses included but were not limited to, congestive heart failure, atrial fibrillation, and. hypertension. A physician's order, dated 5/31/11, indicated "...PT/INR (test for blood clotting time) & BMP (basic metabolic profile) on 6-2-11 then weekly on Monday..." There was a lack of documentation in the resident's record to indicate the laboratory tests had been completed as ordered by the physician. During an interview on 6/2/11 at 3:35 p.m., LPN #3 indicated the laboratory tests had not been drawn today. She indicated they had to draw the blood for the laboratory tests and the laboratory would come and pick it up. She indicated she wanted to be able to draw the blood for both laboratory tests at the same time was why she hadn't done the laboratory tests today. She indicated she had wanted to find out which physician to send the results of the laboratory tests to. The MAR (Medication Administration Record), dated 6/11, indicated "BMP call (physician name) c (with) results...PT/INR call (physician name) c results..."		on all residents for the last 3 months to asure that physician orders wer followed regarding labs. MD will be notified of any labs that were not completed per order.3. DON/Designee will audit Physician orders to identify those orders which contain orders for labs to be completed. This audit will include labs completed to ensure that labs are completed per physician order. This will be done daily (Monday - Friday with Monday's audit to include weekend) X 30 days and then weelkly X 60 days and then monthly. All Nurses will be inserviced regarding following physician orders for labs.4. The DON/ Designee will summarize results of audits and present the data to the Quality Assurance Committee monthly for review to identify additional trends/patterns warranting further corrective action. Audits will continue until the QA Committee determine that a 95% compliance threshold is met.5. Date of Compliance: July 7, 2011	

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	3.1-35(g)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, record review, and interview, the facility failed to ensure a PICC (Peripherally Inserted Central Catheter) was assessed upon removal of the PICC line for 1 of 1 resident with a PICC line and failed to ensure oxygen was administered as ordered by the physician for 1 of 3 residents with oxygen in a total sample of 12 residents. (Residents #1 and #49) Findings include: 1. Resident #1's record was reviewed on 6/2/11 at 2:45 p.m. Resident #1's diagnoses included but were not limited to, congestive heart failure, asthma, and. hypertension.	F0328	F328:1. Resident #49 was discharged on May 19, 2011. Resident #1- Oxygen liter flow was corrected immediately. Residents oxygen order was revised to allow for titration of oxygen for shortness of breath or to keep oxygen saturation levels >90%.2. Any resident with an order to remove a PICC line has the potential to be affected. All residents that have physician orders for oxygen administration have the potential to be affected by alleged deficiency. All residents records with oxygen orders were reviewed and plans of care were updated to match orders.3. All nursing staff will be inserviced on the policy for Oxygen Administration with emphasis on importance of administering correct liter flow. DON/Designee will prepare a	07/07/2011

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	The admission physician's orders, dated 5/31/11, indicated oxygen at 2 liters via (by way of) nasal canula. Resident #1 was observed during the initial tour on 6/1/11 at 9:25 a.m., with LPN #3 present, with her oxygen on 3.5 liters. During interview at that time, LPN #3 indicated the resident's oxygen was suppose to be on 3 liters. LPN #3 then changed the oxygen to 3 liters. Resident #1 was observed on 6/2/11 at 8:15 a.m., with her oxygen on 2.5 liters. LPN #3 was observed checking the resident's oxygen on 6/2/11 at 8:16 a.m.. LPN #3 indicated the resident's oxygen was on 2.5 liters. LPN #3 then changed the resident's oxygen to 2 liters.		master list of residents utilizing oxygen therapy and their physician order for liter flow. List will be updated as needed.Each oxygen administration device (concentrator, liquid tank and/or protable tank) will be labeled with a sticker that will reflect the correct lilter flow. Unit secretary will audit stickers on a weekly basis to ensure that the liter flow is correct. DON/Designee will make rounds twice daily to ensure that residents are on the correct liter flow of oxygen. Any areas of noncompliance will be immediately rectified. Staff members will be subject to 1:1 reinstruction and further disciplinary action as appropriate. Twice daily rounds will be completed X 30 days, then weekly X 60 days and randomly thereafter.All nurses will be inserviced on the policy for removal of a PICC line. DON/Designee will audit any record of a resident who has had removal of a PICC line to ensure proper documentation. Any nurse found to be noncompliant with documentation expectations will be subject to 1:1 reinstruction and further disciplinary action as appropriate. 4. DON/Designee will summarize results of audits and will present data to the Quality Assurance Commettee monthly to identify further trend/patterns that warrant further corrective action. The audits will continue past the original time	

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	2. Resident #49's record was reviewed on 06/03/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, stroke and anemia. A physician's order, dated 05/05/11 indicated an order to discontinue the resident's PICC line. A Nurses' Note, dated 05/05/11 at 9 p.m., indicated, "...PICC line discontinued..." The Nurses' Notes lacked documentation of an assessment of the catheter site, tip integrity, and length. During an interview on 06/03/11 at 10 a.m., the Director of Nursing (DoN) indicated the PICC line should have been measured when it was discontinued. An undated, facility policy, titled, "Central Venous Catheter Procedures Removal of a PICC Line...", received from the DoN on 06/03/11 at 10:15 a.m., indicated, "...Assess the catheter exit site...Inspect the catheter tip and integrity and length. Document procedure...including...catheter integrity and length..."		frame unitl the QA committee determines that a 95% compliance threshold is met.5. Date of Compliance: July 7, 2011	

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	3.1-47(a)(2) 3.1-47(a)(6)			
F0367 SS=D	Therapeutic diets must be prescribed by the attending physician. Based on observation, record review, and interview, the facility failed to provide therapeutic diets as ordered by the resident's physician, related to large meat portions and a protein supplement for 3 of 8 residents with physician's orders for nutritional interventions in a sample of 12. (Residents #8, #24, and #31) Findings include: 1. Resident #31's record was reviewed on 06/01/11 at 12 p.m. The resident's diagnoses included, but were not limited to, anemia and hypertension. The Physician's Recapitulation Orders, dated 06/11, indicated a diet order for large meat portions. A care plan, dated 05/17/11 indicated the resident had low protein levels. The approaches included large meat portions. During an observation on 06/01/11 at	F0367	F376:1. Resident #8: cottage cheese was obtained and served to resident.Resident #24 and resident #31: large meat portions were obtained and served to residents.2. All residents that have orders for therapeutic diets have the potential to be affected. All tray cards were auditied and compared to the physician orders for accuracy. Any changes found were rectified.3. All nursing and dietary staff will be inserviced on following tray cards and making sure that the residents are served their diets per physician orders. Dietary procedure has been changed to include a second staff member to check the tray for accuracy before it is placed in the cart. Dietary Manager/Designee will observe/audit 5 meal tray lines weekly X 30 days, monthly X 60 days and then 5 quarterly to ensure accuracy of diets served. DON/Designee will observe at least 5 dining room meal services weekly X 30 days, 5 monthly X 60 days and then 5 quarterly for accuracy of diets served. Any staff member found to be noncompliant with service of physician ordered diet will be	07/07/2011

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	12:15 p.m., the resident was served beef and noodles, there were 4 cubed pieces of beef on the resident's noodles on his plate. During an observation on 06/01/11 at 5:15 p.m., the resident was served goulash. The goulash was the same serving size as the others at the table had been served. During an interview at the time of the observation, the Director of Nursing indicated it did not look like the resident received a large meat portion. 2. Resident #24's record was reviewed on 06/02/11 at 9 a.m. The resident's diagnoses included, but were not limited to hypertension and congestive heart failure. The Physician's Recapitulation Orders, dated 06/11, indicated an order for large meat servings with lunch and dinner. During an observation on 06/01/11 at 5:20 p.m., the resident was served goulash, which was the same serving size as the other residents had been served.. During an interview on 06/01/11 at 5:30 p.m., CNA #2 indicated the resident received a regular portion of the goulash. 3. Resident #8's record was reviewed on 6/1/11 at 1:00 p.m. Resident #8's		subject to 1:1 reinstruction and further disciplinary action as appropriate.4. DON/Designee will summarize results of audits and present data to the Quality Assurance committee monthly to identify trend/patterns warranting further corrective action. Audits will continue past original time frame until the QA Committee determines that a 95% compliance threshold is met.5. Date of compliance: July 7, 2011	

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	diagnoses included, but were not limited to, diabetes mellitus and severe osteoporosis. A physician's order, dated 5/6/11, indicated "...cottage cheese c (with) each meal." Resident #8 was observed eating his evening meal on 6/1/11 at 5:15 p.m. The resident had not received his cottage cheese with his evening meal. During an interview on 6/1/11 at 5:15 p.m., CNA #4 indicated the kitchen had not sent the resident's cottage cheese. She indicated "thanks for reminding me." 3.1-21(b)			